DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To:	Dental Providers Managed Care Plans	**Memorandum No.: 05-16 MAA** **Issued:** March 30, 2005
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration	**For Information Call:** 1-800-562-6188
Subject:	**Dental Program (Adults/Children): Billing Policy for Oral and Maxillofacial Surgery**	

Effective for claims with dates of service on and after April 1, 2005, the Medical Assistance Administration (MAA) will implement new policy according to WAC 388-535-1070 for dental providers who bill MAA for providing oral and maxillofacial surgery to MAA-eligible clients. MAA is updating the current *Dental Program (Adults/Children) Billing Instructions* to reflect these changes.

What has changed?

Effective for claims with dates of service on and after April 1, 2005, for the dental specialty of oral and maxillofacial surgery:

- MAA requires a dentist to:
  - ✓ Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and
  - ✓ Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:
    - ➢ The dentist must have participated for at least three years in a maxillofacial residency program; and
    - ➢ The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.
- A dental provider who meets the above requirements must bill MAA with appropriate Current Dental Terminology (CDT) codes or Current Procedural Terminology (CPT®) codes for services that are identified as covered in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda.

Enrolled dental providers who do ***not*** meet the above conditions must bill MAA using **ONLY** the CDT codes for services that are identified in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda. MAA does ***not*** reimburse for billed CPT codes when the dental provider does not meet these conditions.

Billing Instructions Replacement Pages

Attached are updated replacement pages B.1/B.2, D.45/D.46, and E.37/E.38 for MAA's current *Dental Program (Adults/Children) Billing Instructions*.

How can I get MAA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Dental Program

What is the purpose of the Dental Program?

The purpose of the Dental Program is to provide quality dental and dental-related services to eligible medical assistance clients.

Becoming a DSHS dental provider [Refer to WAC 388-535-1070(1)]

The following providers are eligible to enroll with the Medical Assistance Administration (MAA) to furnish and bill for dental-related services provided to eligible medical assistance clients:

- Persons currently licensed by the state of Washington to:
  - ✓ Practice dentistry or specialties of dentistry;
  - ✓ Practice as dental hygienists;
  - ✓ Practice as denturists; and/or
  - ✓ Administer anesthesia by:
    - ➢ Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as an anesthesiologist or dental anesthesiologist;
    - ➢ Providing conscious sedation with parenteral or multiple oral agents, deep sedation, or general anesthesia as a Certified Registered Nurse Anesthetist (CRNA) under WAC 246-817-180;
    - ➢ Providing conscious sedation with parenteral or multiple oral agents as a dentist, when the dentist has a conscious sedation permit issued by the Department of Health (DOH) that is current at the time the billed service(s) is provided; or
    - ➢ Providing deep sedation or general anesthesia as a dentist when the dentist has a general anesthesia permit issued by DOH that is current at the time the billed service(s) is provided.
  - ✓ Practice medicine and osteopathy for:
    - ➢ Oral surgery procedures; or
    - ➢ Providing fluoride varnish under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

- Facilities that are:

  - ✓ Hospitals currently licensed by DOH;
  - ✓ Federally-qualified health centers (FQHCs);
  - ✓ Medicare-certified ambulatory surgery centers (ASCs);
  - ✓ Medicare-certified rural health clinics (RHCs); or
  - ✓ Community health centers (CHCs).

- Participating local health jurisdictions; and

- Bordering city and out-of-state providers of dental-related services who are qualified in their states to provide these services.

> ☞ **Note:** MAA pays licensed providers participating in the MAA Dental Program for only those services that are within their scope of practice.
> [Refer to WAC 388-535-1070(2)]

Oral and Maxillofacial Surgery

[Refer to WAC 388-535-1070 (3)]

For the dental specialty of oral and maxillofacial surgery:

- MAA requires a dentist to:

  - ✓ Be currently entitled to such specialty designation (to perform oral and maxillofacial surgery) under WAC 246-817-420; and
  - ✓ Meet the following requirements in order to be reimbursed for oral and maxillofacial surgery:

    - ➢ The dentist must have participated for at least three years in a maxillofacial residency program; and
    - ➢ The dentist must be board certified or designated as "board eligible" by the American Board of Oral and Maxillofacial Surgery.

- A dental provider who meets the above requirements must bill MAA with appropriate Current Dental Terminology (CDT) codes or Current Procedural Terminology (CPT®) codes for services that are identified as covered in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda.

Enrolled dental providers who do ***not*** meet the above conditions must bill MAA using **ONLY** the CDT codes for services that are identified in WAC, MAA's current *Dental Program (Adults/Children) Billing Instructions*, and applicable Numbered Memoranda. MAA does ***not*** reimburse for billed CPT codes when the dental provider does not meet these conditions.

Anesthesia

- MAA covers general anesthesia, conscious sedation, and parenteral or multiple oral agents for medically necessary dental services as follows:

  - ✓ For treatment of clients of the Division of Developmental Disabilities;
  - ✓ For oral surgery procedures;
  - ✓ When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record.
  - ✓ When the anesthesia is administered by:
    - ➢ An oral surgeon;
    - ➢ An anesthesiologist;
    - ➢ A dental anesthesiologist;
    - ➢ A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH);
    - ➢ A dentist who has a conscious sedation permit (for conscious sedation with parenteral or multiple oral agents) issued by DOH that is current at the time the billed service(s) is provided; or
    - ➢ A dentist who has a general anesthesia permit (for deep sedation or general anesthesia) issued by DOH that is current at the time the billed service(s) is provided.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When general anesthesia (including deep sedation) is administered by:

  - ✓ The attending dentist, MAA reimburses at the rate of 50% of the maximum allowable rate.
  - ✓ A provider other than the attending dentist, MAA reimburses at the maximum allowable rate.

- When billing for general anesthesia, show the beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision).

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

• MAA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist: **$101.20 + [TIME UNITS X $20.24] = MAXIMUM ALLOWABLE FEE** **Note: Every 15 minute increment or fraction equals 1 time unit.**				
• Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*).				
D9220	**Deep sedation/general anesthesia** When justification for administering the general anesthesia instead of a lesser type of sedation is clearly documented in the client's record. MAA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(A General Anesthesia permit is required to be on file with MAA from the provider/performing provider.)**	No	**By Report**	**By Report**
D9230	**Analgesia, anxiolysis, inhalation of nitrous oxide** MAA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	$6.18	$ 6.18 **DDD clients only**
D9241	**Intravenous conscious sedation/analgesia** Conscious sedation with parenteral agents. **(A Conscious Sedation permit is required to be on file with MAA from the provider/performing provider.)**	No	$50.00	50.00

Anesthesia

- MAA covers the following anesthesia services :

  General Anesthesia

  - For treatment of adult clients of the Division of Developmental Disabilities;
  - When medically necessary for those oral surgery CPT procedure codes listed on pages F.5-F.15;

  Conscious Sedation

  - For treatment of adult clients of the Division of Developmental Disabilities;
  - When medically necessary for those oral surgery CPT procedure codes listed on pages F.5-F.15 and those surgical extraction CDT codes listed on page E.35;

- MAA covers the above anesthesia services when the anesthesia is administered by:

  - An oral surgeon;
  - An anesthesiologist;
  - A dental anesthesiologist;
  - A Certified Registered Nurse Anesthetist (CRNA), if the performing dentist has a current conscious sedation permit or a current general anesthesia permit from the Department of Health (DOH);
  - A dentist who has a conscious sedation permit (for conscious sedation with parenteral or multiple oral agents) issued by DOH that is current at the time the billed service(s) is provided; or
  - A dentist who has a general anesthesia permit (for deep sedation or general anesthesia) issued by DOH that is current at the time the billed service(s) is provided.

- When the provider meets the prevailing standard of care and at least the requirements in WAC 246-817-760, Conscious sedations with parenteral or multiple oral agents, and WAC 246-817-770, General anesthesia.

- When billing for general anesthesia, show the beginning and ending times on the claim form. State the total number of minutes on the claim. Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under post-operative supervision)

- When general anesthesia (including deep sedation) is administered by:

  - ✓ The attending dentist, MAA reimburses at the rate of 50% of the maximum allowable rate.
  - ✓ A provider other than the attending dentist, MAA reimburses at the maximum allowable rate.

- The name of the provider who administered the anesthesia must be in the *Remarks* field (field 35) of the claim form, if that provider is different from the billing provider.

- MAA calculates payment according to the formula below for general anesthesia (to include deep sedation) administered by a dentist:

  $101.20 + [TIME UNITS X $20.24] = MAXIMUM ALLOWABLE FEE
  Note: Every 15 minute increment or fraction equals one time unit.

  - Bill for pharmaceuticals using the appropriate code(s) below. If you are billing electronically, attach an itemized list of pharmaceuticals to the claim form. Send this information to MAA as backup documentation for electronically billed claims for any charges exceeding $45.00 (see *Important Contacts*).
  - Documentation of medical necessity must be kept in the client's file.

D9220	Deep sedation/general anesthesia MAA's reimbursement for D9220 **includes the total time** – not just the first 30 minutes as specified in the CDT book. See previous page for further information. **(The provider's/performing provider's General Anesthesia permit is required to be on file with MAA.)**	No	**By Report**
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide MAA does not cover analgesia or anxiolysis under the Dental Program. Use this code when billing for inhalation of nitrous oxide.	No	$6.18 **DDD clients only**
D9241	Intravenous conscious sedation/analgesia **Conscious sedation with parenteral agents.** **(The provider's/performing provider's Conscious Sedation permit is required to be on file with MAA.)**	No	50.00
D9248	**Non-intravenous conscious sedation** Conscious sedation with multiple oral agents. **(The provider's/performing provider's Conscious Sedation permit is required to be on file with MAA.)**	No	50.00